

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-012886

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318**
FILED APR 6 1962

Primary Registration District No.

1003

Registrar's No. **3399**

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN **St. Louis**Length of stay in 1b
8 Daysc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION **Lutheran Hospital**Inside Limits
Yes ☐ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo.** b. COUNTYc. CITY OR TOWN **St. Louis** Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location) **4400 a Morganford ave.** Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)First **Rose** Middle **M.** Last **Krause**4. DATE OF DEATH Month **March** Day **29** Year **1962**5. SEX
Female6. COLOR OR RACE
White7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐8. DATE OF BIRTH
2-2-19049. AGE (last birthday)
58IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HR10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife10b. KIND OF BUSINESS OR INDUSTRY
Own Home11. BIRTHPLACE (City and state or country)
St. Louis, Mo.12. CITIZEN OF WHAT COUNTRY
U S A

13a. FATHER'S NAME

George Bollinger

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Oscar F.15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT Address
Oscar F. Krause 4400 A. Morganford18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral & LiverINTERVAL BETWEEN ONSET AND DEATH
6 weeks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

581.0x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Cerebral - subarachnoid hemorrhage

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **1/10/62** to **3/29/62** and last saw her alive on **3/29/62**
Death occurred at **10.15 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Edward W. Gibbins M.D.

(Degree or title)

22b. ADDRESS

3701 Cranford St.

22c. DATE SIGNED

3/30/6223a. BURIAL, CREMATION, REMOVAL (Specify)
Burial23b. DATE
4-2-6223c. NAME OF CEMETERY OR CREMATORY
St. Matthews Cemetery23d. LOCATION (City, town, or county) (State)
4360 Bates St.24. FUNERAL DIRECTOR ADDRESS
C. Hoffmeister Mortuaries
7811 S. Broadway25. DATE RECD. BY LOCAL REG.
MAR 30 1962

26. REGISTRAR'S SIGNATURE

Earl Smith M.D.USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Levin C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

DR. EDW. W. GEORGINSKI 3701 GRANDEL DE-3-44
1-3-30 PM.